CHOICES FOR CARE
PERMISSION FOR RELEASE OF INFORMATION

NAME: _____
(print)

I give my permission for the Department of Disabilities, Aging and Independent Living (DAIL) Long-Term Care Clinical Coordinator to share information contained in my **Choices for Care** application and assessment with the Department for Children and Families, my legal representative, the local Waiver team, and all applicable **Choices for Care** program providers. In addition, I give permission to share with the following:

- ☐ Family/Friend: _____
- ☐ Physician: _____
- ☐ Mental Health Agency:_____
- ☐ Housing Provider:_____
- ☐ Other(s):_____
- ☐ Other(s):_____

Individualized Instructions (if any): _____

_____

I understand that all information will be respected as confidential by these entities and that it will be used solely to facilitate **Choices for Care** eligibility determination, service coordination and program monitoring. I understand that if I decline to release information, it may affect my eligibility for the **Choices for Care** program.

I have read this **RELEASE OF INFORMATION,** and I agree to its terms as stated or amended. I understand that I may, at any time, revoke my consent to share any or all of the information by calling or writing the DAIL Long-Term Care Clinical Coordinator (LTCCC) listed below:

_____
DAIL LTCCC Name Phone Number

Individual/Legal Representative Signature: _____

Consent to share this information expires on _____(no more than one year)
date